USF Health

UNIVERSITY OF SOUTH FLORIDA – MORSANI COLLEGE OF MEDICINE

GME Completion Certificate Request Form

DATE: _____

Requested by: _____ Contact E-mail: _____

Maiden Name (*if applicable*): _____ Contact Ph: _____

By signing this form, I confirm that I completed training at University of South Florida Morsani College of Medicine (USF MCOM) in the program listed below during the indicated dates. I am requesting a replacement copy of my training completion certificate and understand that there is a $25 charge, per certificate, associated with this request, and hereby release USF MCOM from all liability for the release of this information.

Certificate Information (PRINT)

NAME: _____

PROGRAM(s):

_____ Date(s): From _____To _____

_____ Date(s): From _____To _____

Print Legal Name of Authorizing Physician: _____

SIGNATURE of Authorizing Physician: _____
(Your signature must be acknowledged before a Notary Public)

Shipping Information: (PRINT the name/address where the certificate should be mailed to)
NAME: _____
STREET ADDRESS: _____
CITY, STATE, ZIP: _____

Notary Section

State of _____
County of _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____
by _____ (name of person acknowledging).

SEAL:

_____
Signature of Notary Public
Print, Type/Stamp Name of Notary

☐ Personally known
☐ Produced Identification
Type of Identification Produced: _____

Note: Return completed form with a $25 check for each certificate to: USF Health Payment Center, PO BOX 737444, DALLAS, TX 75373-7444